STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING O1 COMPLETED			ETED
		155165	B. WIN			12/20/	2012
NAME OF I	DDOVIDED OD GUDDI IE	Th.	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	.K		586 EA	STERN BLVD		
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
K0000							
	A Life Safety (ada Rocartification	K00	000	Submission of this plan of sorrestion	•	
	1	Code Recertification	Koo	100	Submission of this plan of correction does not constitute admission or	1	
		nsure Survey was			agreement by the provider of the		
	1	the Indiana State			truth of facts alleged or correction		
	Department o				set forth on the statement of		
	accordance wi	th 42 CFR 483.70(a).			deficiencies. This plan of correction		
					is prepared and submitted because		
	Survey Date:	12/20/12			of requirement under state and		
					federal law.Please accept this plan		
	Facility Numb	er: 000082			of correction as our credible		
	Provider Num				allegation of compliance. Please find	d	
	AIM Number:				enclosed the plan of correction for		
	Alm Nullibel.	100289040			the survey ending December 20,		
					2012.		
	· ·	rk Bugni, Life Safety					
	Code Specialis	st					
		(
		fety Code survey,					
		ige was found not in					
	compliance w	ith Requirements for					
	Participation i	n					
	Medicare/Med	licaid, 42 CFR					
	Subpart 483.7	'O(a), Life Safety					
		the 2000 edition of					
	the National F						
		IFPA) 101, Life Safety					
		•					
		hapter 19, Existing					
		ccupancies and 410					
	IAC 16.2.						
		6 110					
	This two story	=					
		be of Type II (111)					
	construction a	and fully sprinklered.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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TITLE

PRINTED: 01/17/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165		Ì	LDING	NSTRUCTION 01	(X3) DATE COMPL 12/20/	ETED	
	PROVIDER OR SUPPLIER		D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE STERN BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	with smoke derincluding the copen to the coroperated smok resident sleeping facility has a can had a census of this visit. All areas where customary acceeding the first exit stairway not overhang, the fall exit stairway six foot overhang, and I stairway six foot overhang facility sprinklered exit wo story launce detached eight storage shed, the foot by sixteen building, and fourteen foot by storage sheds. The facility was compliance with aforementioned and the coroperate with aforementioned and the coroperated sheds.	e residents have ess were sprinklered foot by six foot first floor Kitchen ay nine foot by six and the first floor exit nine foot by ng. All areas ty services were tept the detached dry building, the foot by thirty foot he detached twenty foot old smokers ive detached by twelve foot s found not in h the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N5L721

Facility ID: 000082

If continuation sheet

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PRINTED: 01/17/2013 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165		A. BUILDING B. WING	01	COMP	COMPLETED 12/20/2012		
RIVERVI	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE		
	following:							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N5L721

Facility ID: 000082

If continuation sheet Page 3 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING O1 COMPLETED			ETED	
		155165	B. WIN			12/20/2012	
			B. ((11)		ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF P	ROVIDER OR SUPPLIER	t .			STERN BLVD		
RIVERVII	EW VILLAGE			CLARKSVILLE, IN 47129			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG K0025	NFPA 101	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE
SS=E	LIFE SAFETY CO	ODE STANDARD					
00-L		re constructed to provide at					
		our fire resistance rating in					
		8.3. Smoke barriers may					
		trium wall. Windows are					
	•	rated glazing or by wired steel frames. A minimum					
	• .	ompartments are provided					
		mpers are not required in					
	•	of smoke barriers in fully					
		entilating, and air					
	19.1.6.3, 19.1.6.4	ems. 19.3.7.3, 19.3.7.5,					
	1. Based on ob	oservation and	K00)25	K 025NFPA 101 LIFE SAFET	Y	01/19/2013
	interview, the f	facility failed to			CODE STANDARD requires		
	ensure 1 of 8 a	attic smoke barriers			thatSmoke barriers are constructed to provide at least	а	
	was constructe	ed to provide at			one half hour fire resistance	_	
	least a one half	f hour fire			rating in accordance with 8.3.		
	resistance ratir	ng. This deficient			Smoke barriers may terminate	at	
	practice affects	s 18 residents who			an atrium wall. Windows are protected by fire-rated glazing	or	
	reside on the s	econd floor F Hall.			by wired glass panels and stee		
					frames. A minimum of two		
	Findings includ	łe·			separate compartments are		
					provided on each floor. Dampe	ers	
	Rased on obse	rvation with the			are not required in duct penetrations of smoke barriers	in	
	maintenance s				fully ducted heating, ventilating		
		on 12/20/12 at			and air conditioning systems.		
					The facility will ensure this		
	12:45 p.m., the				requirement is met through the		
		ove smoke barrier			following: 1. No residents were harmed. The areas identified		
		eight inch area near			concerns were repaired and		
		ne smoke barrier			replaced with approved fire-ra		
		ywall, a three inch			caulking including: A. An eigh	t	
	circular area or	n the east side of			inch area, in the F Hall above		
	the smoke barr	rier wall with no			smoke barrier doors, near the center of the smoke barrier wa	all	
	drywall, and a	six inch by six inch			B. The three inch circular area		
			1		<u> </u>	-	

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Event ID: N5L721

Facility ID: 000082

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETE	
		155165	B. WIN	IG		12/20/201	2
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			586 EASTERN BLVD			
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re CC	OMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG			DATE
		iter of the smoke			the F Hall above the smoke barrier doors, on the east side	of	
	barrier wall fill	ed with non rated			the smoke barrier wall. C. The		
	yellow expand	able foam. Based			six inch area in the center of the		
	on an interviev	v with the			smoke barrier wall. D. The two	elve	
	maintenance s	upervisor on			inch by six inch area in the firs		
	12/20/12 at 1	2:55 p.m., the			floor elevator equipment room		
		able foam is not a			ceiling. E. Two, two inch by tw inch areas of drywall missing i		
	1 -	uct. The F Hall			the first floor elevator equipme		
	-	II and non rated			room. 2. All residents have the	e	
	yellow expand				potential to be affected. Facilit	•	
	1 '				inspected to ensure no further areas of concern. 3. Maintena		
	verified by the				staff in-serviced on K025 on D		
		l administrator at			21st, 2012 by Administrator(Se		
	the time of ob				Attachment A). 4. The		
	I -	he administrator at			Administrator or designee will		
		exit conference on			utilize the Preventative		
	12/20/12.				Maintenance Monitoring Tool monthly times 3 months and the	nen	
					Quarterly until compliance has		
	3.1-19(b)				been maintained for 2		
					consecutive quarters (See		
	2. Based on o	bservations and			Attachment B). The audits will	be	
	interview, the	facility failed to			reviewed during the facilities quality assurance meeting and	,	
		oke barriers in 1 of			issues will be addressed and t		
		oom ceilings was			above plan will be altered	-	
		provide at least a			accordingly, if needed. 5. The		
	one half hour f				above plan of correction will be		
		3.2 requires smoke			completed on or before Janua 19 th , 2013.	ry	
	1	oe continuous from			13 11, 2013.		
		I to an outside wall.					
		practice could affect					
		ents who would use					
		dining room, next to					
	the kitchen. L	SC Section 8.3.6.1					
	requires the pa	assage of building					
	1		1			1	

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	of Correction identification number: 155165	A. BUILDING B. WING	01	COMPLETED 12/20/2012		
	PROVIDER OR SUPPLIER EW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE COMPL		
	service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 40 residents who use the main dining room, which is located near the elevator equipment room. Findings include: Based on observation on 12/20/12 at 9:45 a.m. with the maintenance supervisor and administrator, the first floor elevator equipment room ceiling had a twelve inch by six inch area and two, two inch by two inch areas of drywall missing. This was verified by the maintenance supervisor and administrator at the time of observation and confirmed by the administrator at the 1:30 p.m. exit conference on 12/20/12. 3.1–19(b)					

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Event ID: N5L721

Facility ID: 000082

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155165	B. WING		12/20/2012
NAME OF I	PROVIDER OR SUPPLIE	D.	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIE	K.	586 EA	STERN BLVD	
RIVERVI	EW VILLAGE		CLARK	SVILLE, IN 47129	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K0029 SS=E	NFPA 101	ODE STANDARD			
33-E		ed construction (with ¾			
		pors) or an approved			
	automatic fire ex	tinguishing system in			
		8.4.1 and/or 19.3.5.4			
	· ·	ous areas. When the			
		atic fire extinguishing used, the areas are	1		
		other spaces by smoke			
		ns and doors. Doors are			
	_	non-rated or field-applied			
		that do not exceed 48			
		oottom of the door are 3.2.1			
	Based on obse		K0029	K 029 NFPA 101 LIFE SAFET	Y 01/19/2013
			K002)	CODE STANDARDOne hour f	
		facility failed to ridor door to 1 of		rated construction (with 3/4 hou	
		nazardous areas,		fire-rated doors) or an approve	ed
		fired heater room,		automatic fire extinguishing system in accordance with 8.4	. 1
	was provided			and/or 19.3.5.4 protects	
	•	. This deficient		hazardous areas. When the	
		affect 40 residents		approved automatic fire extinguishing system option is	
	· .	nain dining room,		used, the areas are separated	
		nt to the kitchen.		from other spaces by smoke	
	iocateu aujace	in to the kitchell.		resisting partitions and doors.	
	Finalinas instru	d		Doors are self-closing and non-rated or field-applied	
	Findings inclu	ue.		protective plates that do not	
	Dagad an abar	un rationa an		exceed 48 inches from the	
	Based on obse		1	bottom of the door are permitte	ed.
	· ·	0:30 a.m. with the		The facility will ensure this	
	maintenance s			requirement is met through the following: 1. No residents were	
	•	the kitchen natural	1	harmed. The door in the kitch	
		ot water heater		natural gas powered hot water	
	room door fail	ed to self close and		heater room, which failed to se	elf
	was propped o	ppen sixteen inches	1	close, was repaired. 2. All	
	by the door dr	agging on the		residents have the potential to affected. Facility inspected to	De
				ancolod. I acinty mapecied to	

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Event ID: N5L721

Facility ID: 000082

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	OF CORRECTION IDENTIFICATION NUMBER: 155165	A. BUILDING B. WING	COMPLETED 12/20/2012
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE TAG	BE COMPLETION
	concrete floor. This was verified by the maintenance supervisor and administrator at the time of observation and confirmed by the administrator at the 1:30 p.m. exit conference on 12/20/12. 3.1–19(b)	ensure no further areas of concern. 3. Maintenance sin-serviced on K029 on December 21st, 2012 by Administrator (See Attat A). Dietary Staff will be in-serviced on or before January 19th, 2012 by Maintenance Director on K The Administrator or designatilize the Preventative Maintenance Monitoring Tomonthly times 3 months and Quarterly until compliance been maintained for 2 consecutive quarters (See Attachment B). The audits reviewed during the facilitie quality assurance meeting issues will be addressed at above plan will be altered accordingly, if needed. 5. Tabove plan of correction with completed on or before January 19 th, 2013.	chment 029.4. nee will ool od then has will be es and nd the

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Event ID: N5L721

Facility ID: 000082

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	01	COMPL	ETED
		155165	B. WIN			12/20/	2012
NAME OF D	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			586 EA	STERN BLVD		
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
K0056	NFPA 101	LSC IDENTIFYING INFORMATION)		TAG	DLI ICILICE I		DATE
SS=F	LIFE SAFETY CO						
		matic sprinkler system, it is dance with NFPA 13,					
		Installation of Sprinkler					
		de complete coverage for					
	•	building. The system is					
		ed in accordance with ard for the Inspection,					
		ntenance of Water-Based					
	Fire Protection Sy						
		e is a reliable, adequate					
		he system. Required					
		are equipped with water switches, which are					
		cted to the building fire					
	alarm system.	19.3.5					
	Based on obse	rvation and	K00)56	K 056NFPA 101 LIFE SAFET		01/19/2013
	interview, the f	facility failed to			CODE STANDARDIf there is a automatic sprinkler system, it i		
	ensure 3 of 4 s	tairway exit		installed in accordance with		3	
	overhangs wer				NFPA 13, Standard for the		
	sprinklered. T	his deficient			Installation of Sprinkler System		
	practice affects	s 8 residents who			to provide complete coverage all portions of the building. Th		
		y room at a time, 40			system is properly maintained		
		use the main dining			accordance with NFPA 25,		
	room located n	near the first floor			Standard for the Inspection, Testing, and Maintenance of		
	<u> </u>	elow the second			Water-Based Fire Protection		
		nce Hall, and 19			Systems. It is fully supervised		
		reside on the A			There is a reliable, adequate		
	Hall.				water supply for the system. Required sprinkler systems are	<u>.</u>	
					equipped with water flow and	-	
	Findings includ	le:			tamper switches, which are		
					electrically connected to the		
	Based on obse	rvations on			building fire alarm system. Th facility will ensure this	е	
	12/20/12 duri	ng a tour of the			requirement is met through the)	
	facility with the	e maintenance			following: 1. No residents were	;	
	supervisor and	administrator from			harmed. The areas identified	as	

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	of correction identification number: 155165	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPLETED 12/20/2012
	PROVIDER OR SUPPLIER EW VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	586 EA	ADDRESS, CITY, STATE, ZIP CODE STERN BLVD (SVILLE, IN 47129 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	8:30 a.m. to 1:30 p.m., the first floor Kitchen Hall stairway exit overhang, the first floor therapy room stairway exit overhang, and the first floor A Hall stairway exit overhang, each measuring nine feet by six feet, were not provided with sprinkler coverage. This was verified by the maintenance supervisor and administrator at the time of observations and confirmed by the administrator at the 1:30 p.m. exit conference on 12/20/12. 3.1–19(b)	TAG	a concern will be equipped withe appropriate sprinkler systicicluding; A. The first floor Kitchen Hall stairway exit overhang. B. The first floor therapy room stairway exit overhang. C. The first floor A stairway exit overhang. 2. All residents have the potential to affected. Facility inspected to ensure no further areas of concern. 3. Maintenance staff in-serviced on K056 on December 21st, 2012 by Administrator (See Attachmer A). 4. The sprinkler system who be maintained as part of the Preventative Maintenance Program. 5. The above plan of correction will be completed to before January 19 th , 2013.	ith em Hall b be f nt vill

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Event ID: N5L721

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIIII	BUILDING 01		COMPLETED	
		155165	B. WIN			12/20/	2012
C OF P					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			586 EA	STERN BLVD		
RIVERVI	EW VILLAGE			CLARKSVILLE, IN 47129			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG K0062	NFPA 101	LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCE)		DATE
SS=E	continuously main condition and are periodically. 19 NFPA 25, 9.7.5 Based on obserview, the frensure 1 of 1 cours provided was provided	tic sprinkler systems are intained in reliable operating inspected and tested 0.7.6, 4.6.12, NFPA 13, rvation and facility failed to outside overhangs with sprinkler heads on. 9.7.5 refers to dard for the sting, and f Water-Based Fire ems. NFPA 25, es sprinklers to be	K00	062	K 062NFPA 101 LIFE SAFETY CODE STANDARD states that required automatic sprinkler systems are continuously maintained in reliable operatin condition and are inspected ar tested periodically. The facility will ensure this requirement is met through the following: 1. No residents were harmed. The sprinklers identified as an area concern on the front entrance outside overhang will be replaced.	g and / lo a of ced.	01/19/2013
	materials, pain damage and she proper oried pendent, or side sprinkler shall painted, corroctloaded, or in the orientation. The practice could who use the act at the front entering sinclus assed on observations.	t, and physical hall be installed in entation (upright, lewall). Any be replaced that is ded, damaged, he improper his deficient affect 8 residents stivity bus at a time trance. de: evation on 2:10 p.m. with the			2. All residents have the potento be affected. Facility inspected to ensure no further areas of concern. 3. Maintenance staff in-serviced on K062 on December 21st, 2012 by Administrator (See Attachmen A). 4. The Administrator or designee will utilize the Preventative Maintenance Monitoring Tool monthly to ensure compliance is maintain (See Attachment B). The audit will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan be altered accordingly, if need 5. The above plan of correction will be completed on or before January 19, 2013.	ed t ed s will ed. n	

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Event ID: N5L721

Facility ID: 000082

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	OF CORRECTION IDENTIFICATION NUMBER: 155165	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 12/20/2012		
	PROVIDER OR SUPPLIER EW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION		
	administrator, the front entrance outside overhang had six sprinklers completely covered with green corrosion. This was verified by the maintenance supervisor and administrator at the time of observation and confirmed by the administrator at the 1:30 p.m. exit conference on 12/20/12. 3.1–19(b)					

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